# SECTION 10
# FORMS

On the following pages are copies of various forms used by the MO HealthNet Psychology/Counseling program.

- Go to the MO HealthNet Web site, http://dss.mo.gov/mhd/providers/ and select and click on ”forms” under Provider Information.

STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES

# PSYCHOLOGICAL SERVICES REQUEST FOR PRIOR AUTHORIZATION

| PARTICIPANT NAME (LAST, FIRST, M.I.) | | PROVIDER NAME (AFFIX LABEL HERE) |
|---|---|---|
| PARTICIPANT NUMBER | BILLING PROVIDER IDENTIFIER | PROVIDER TAXONOMY CODE (IF REQUIRED) |
| DATE OF BIRTH | PROVIDER TELEPHONE NUMBER | PROVIDER FAX NUMBER |
| PROVIDER SIGNATURE | | DATE |
| NUMBER OF HOURS USED ON CURRENT PA* | | HOURS USED AS OF (DATE) |
| REQUESTED START DATE OF PA | | |

1. Service Requested (If requesting Family Therapy please see reminder in instructions)
   Services that **always** require a PA for all participants:
   Children – Birth through 2 years old
   ☐ Assessment Hours _____ ☐ Testing Hours _____ ☐ Therapy - Therapy Type _____ Hours _____
   All Ages
   ☐ Individual Interactive Therapy Hours _____ ☐ Family Therapy without patient present Hours _____

   Services that require PA per program guidelines:
   ☐ Individual Therapy Hours _____ ☐ Family Therapy** Hours _____ ☐ Group Therapy Hours _____
   ☐ Individual and Family Therapy Combination** Hours Individual _____ Hours Family _____
   **If requesting Family Therapy, please list all members of the family, relationship to patient and DCN if available.

2. Has the patient/guardian agreed to his/her treatment plan? ☐ Yes ☐ No
3. Is the therapy court ordered? ☐ Yes ☐ No
4. Have you communicated with other involved therapist/health care practitioner about treatment? ☐ Yes ☐ No
5. If child is in state custody, have you provided a copy of the treatment plan to the Children's Division casemanager or contracted casemanager? If yes, date _____ ☐ Yes ☐ No
   Casemanager Name _____ ☐ Child not in state custody
6. Is therapy the result of an EPSDT screen? If yes, date of screen _____ ☐ Yes ☐ No

**AXIS I: CLINICAL DISORDERS OR OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTIONS**

| DIAGNOSTIC CODE | DIAGNOSTIC CODE |
|---|---|
| | |

IS THERE EVIDENCE OF SUBSTANCE ABUSE?
☐ Yes ☐ No

**AXIS II: PERSONALITY DISORDERS, MENTAL RETARDATION**

| DIAGNOSTIC CODE | DIAGNOSTIC CODE |
|---|---|
| | |

**AXIS III: GENERAL MEDICAL CONDITIONS**

DOES THIS PATIENT HAVE A CURRENT GENERAL MEDICAL CONDITION THAT IS POTENTIALLY RELEVANT TO THE UNDERSTANDING OR MANAGEMENT OF THE CONDITION(S) NOTED IN AXIS I OR II?
☐ Yes ☐ No If Yes, list condition: _____

**AXIS IV: PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS (PLEASE INDICATE ALL THAT APPLY)**

☐ Problems with primary support group
☐ Problems related to social environment
☐ Problems with access to health care
☐ None
☐ Other psychosocial and environmental problems
☐ Problems related to interaction with legal system/crime
☐ Economic problems
☐ Occupational problems
☐ Educational problems
☐ Housing problems

**AXIS V: GLOBAL ASSESSMENT OF FUNCTIONING** (CHECK ONE AND LIST SCORE) ☐ MODIFIED GAF AGE 18 AND OLDER ☐ C-GAS AGE 6-17

| SCORE | DATE |
|---|---|
| | |

*Please see instructions on reverse side of form **Please see instructions on reverse side of form

MO 886-4140 (6-08)

**INSTRUCTIONS FOR COMPLETION**

**HEADER INFORMATION**

**Participant Name, Number and Date of Birth** – Enter the participant's information as it appears on the MO HealthNet ID card.

**Provider Name** – Enter the provider name.

**Billing Provider Identifier** – Enter the provider identifier (NPI) that will be used for billing services to MO HealthNet. If this is a clinic/group setting the clinic number should be entered here.

**Provider Taxonomy Code** – Enter the Taxonomy code (if required)

**Provider Telephone Number** – Enter current telephone number of the provider making the request.

**Provider Fax Number** – Enter the fax number of the provider making the request.

**Signature/Date** – The provider of services should sign the request and indicate the date the form was completed.

***Number of Hours used on current PA** – If the current PA was approved for less than 10 hours, a continued treatment request can be made when 40% of the existing PA hours have been used. If the current PA was approved for 10 hours or more, the continued treatment request can be made when 75% of the existing PA hours have been used.

**QUESTIONS NUMBER 1 THROUGH 7** MUST BE COMPLETED FOR THERAPIES REQUESTED.

**Requested Start Date of PA** – Please indicate the date you would like for your PA to begin. NOTE: The authorized start is the date of receipt or noted subsequent date.

Hours requested for Assessment and Diagnostic Testing must be noted in order to be authorized. Individual Interactive Therapy, Family Therapy Without the Patient Present, and all services for children ages birth through 2 years of age require documentation at all times.

****REMINDER:** When requesting Family Therapy, please list all members of the family. Only one (1) PA will be approved and open at a time for Family Therapy. If there is more than one eligible child and no child is exclusively identified as the primary patient of treatment, then the oldest child's DCN MUST be used for PA and billing purposes. **PROVIDERS SHOULD NOT REQUEST MORE THAN ONE (1) FAMILY THERAPY PRIOR AUTHORIZATION PER FAMILY.** Each child may not be seen separately with parents and billed as Family Therapy.

If therapy is the result of a court order a copy should be kept in the patient's file and a copy of the court order should be forwarded along with any continued therapy request.

**DSM-IV-TR MULTIAXIAL ASSESSMENT** MUST BE COMPLETED

Axis I – Clinical Disorders

Axis II – Personality Disorders, Mental Retardation

Axis III – General Medical Conditions

Axis IV – Psychosocial and Environmental Problems

Axis V – Global Assessment of Functioning

Prior authorization request may be phoned, faxed or mailed into the call center (see below)

InfoCrossing
P.O. Box 4800
Jefferson City, MO 65102
Phone (toll free) 866-771-3350
Fax 573-635-6516

AN APPROVED AUTHORIZATION APPROVES ONLY THE MEDICAL NECESSITY OF THE SERVICE AND DOES NOT GUARANTEE PAYMENT.

MO 886-4140 (6-08)

**PHARMACOLOGICAL MANAGEMENT - 90862**

Participant Name: _____ Provider name: _____
Participant DCN: _____
Date of Visit: _____ Location/Setting:_____
Begin and End Time: _____
Current Diagnosis (should be updated annually, at a minimum): _____
_____
Prescribed and/or Continued Medications: Dose/Frequency:
_____
_____
_____
_____
_____
_____
Current Symptoms:
_____
_____
_____
Mental Status:
_____
_____
_____
Response to treatment/Side Effects:
_____
_____
_____
Medication Changes/Adjustments:
_____
_____
_____
Labs/Tests done or pending:
_____
_____
_____
Recommendations/Plan:
_____
_____
_____

**Provider Signature** _____ **Date** _____